Electronically Delivered

September 19, 2022

Administrator
Peace Home
4953 Aldrich Avenue South
Minneapolis, MN 55419

RE: Project Number(s) SL30414015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 3, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

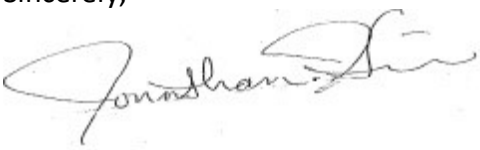
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30414	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE HOME	4953 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55419

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30414015 On August 1, 2022, through August 3, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were nine (9) residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 460	Continued From page 1	0 460		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 460		

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0 460	Continued From page 2 The findings include: During the entrance conference on August 1, 2022, at 10:42 a.m. licensed assisted living director (LALD)-B confirmed the facility did not have a call system in place for residents to request assistance when needed, 24 hours a day, seven days a week. On August 2, 2022, at approximately 2:15 p.m., the surveyor observed the lack of a call system in R1's room to notify staff when R1 needed assistance. At that time, R1 stated that when she needs assistance, she stands at the top of the stairs and yells for staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 1, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this	0 650		

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0 650	Continued From page 4 chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure annual performance reviews, orientation, and annual training were completed for one of two employees (unlicensed personnel (ULP)-C) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 650		

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0 650	Continued From page 5 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired to provide comprehensive homecare services on November 19, 2019; ULP-C began providing assisted living services on August 1, 2021. The employee record of ULP-C did not contain documentation ULP-C had received annual performance reviews, annual training, and orientation required by Assisted Living statutes. On August 2, 2022, at approximately 2:45 p.m. the director of operations (DO)-E verified ULP-C's record lacked evidence the employee had received performance reviews, annual training, and required orientation. DO-E explained that ULP-C may have received performance reviews, annual training, and required orientation, but human resources director (HRD)-H was the only staff with access to these records, HRD-H worked remotely at another location, and HRD-H had another job and was not available to access this licensee's records during the day. The licensee's Personnel Records policy, dated August 1, 2022, directed a personnel file include annual performance reviews, orientation records, and annual training records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 6 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) was completed and documented for one of two employees (unlicensed personnel (ULP)-D) with employee records reviewed. This had the potential to affect all nine residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	0 660		

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0 660	Continued From page 7 of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired by the licensee on January 10, 2022, to provide direct care services. ULP-D's employee record lacked: - current documentation of a completed health history and symptom screening; - completion of a two-step TST or other evidence of TB screening such as a blood test upon hire. On August 1, 2022, at approximately 11:26 a.m. licensed assisted living director (LALD)-B verified lack of completion of symptom screening and a two-step TST or other evidence of TB screening such as a blood test upon hire for ULP-D. The licensee's Tuberculosis Screening policy, dated July 30, 2021, indicated the agency would establish and maintain a TB prevention and control program based on the most current guidelines issued by the Center for Disease Control and Prevention (CDC) and the Minnesota Depart of Health guidelines would be followed. The policy indicated staff would be screened and tested for tuberculosis upon orientation and as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 8 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency disaster plan with all required content. This had the potential to affect all nine residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680		

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0 680	Continued From page 9	0 680		

problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).
The findings include:

On August 1, 2022, at approximately 2:00 p.m., a request was made to view the licensee's emergency preparedness plan, which was later reviewed by the surveyor.

On August 2, 2022, at approximately 2:00 p.m., licensed assisted living director (LALD)-B and director of operations (DO)-E provided some documents regarding emergency planning and confirmed the licensee's emergency preparedness plan had not been completed.
The licensee's plan lacked the following required content:
-current, all-hazards approach facility assessment
-description of the population served by licensee;
-process for emergency preparedness (EP) cooperation with state and local EP officials/organizations.
-subsistence needs for staff and residents during emergency situation;
-procedure for tracking staff and residents'
-development of all policies/procedures, based on assessment; and additional policies for:
    -potential evacuation;
    -sheltering in place;
    -handling medical documents;
    -handling and use of volunteers;
-arrangement with other facilities (including sister facilities);
-development of a communication plan, including primary and alternate means for communication;
-methods for sharing information;
-EP training and testing program;
-EP training program for staff (including documentation of training provided);

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0 680	Continued From page 10 -annual EP testing requirements. The licensee's Disaster Planning and Emergency Preparedness policy, dated August 14, 2015, indicated the licensee would have in place a general emergency preparedness plan. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that the appropriate records for two of nineteen employees (unlicensed personnel (ULP)-C, ULP-D) were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 720		

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0 720	Continued From page 11 or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference, on August 1, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-B confirmed employee records would be available to the surveyor using the licensee's electronic and paper records. During surveyor employee record review process, on August 2, 2022, at approximately 2:00 p.m., the surveyor was unable to access employee records for ULP-C and ULP-D pertaining to background studies and employee training. LALD-B and director of operations (DO)-E stated some employee records were not available at the licensee's location because human resources director (HRD)-H was the only employee with access to some records, worked remotely, and had another job during daytime business hours. RN-B and DO-E confirmed they would try to access requested records from HRD-H during the evening, but were unsure what records HRD-H could provide. The licensee's Personnel Records policy, dated August 1, 2022, directed the licensee's personnel records comply with home care law and other relevant laws. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 720		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 12 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems	0 780		

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0 780	Continued From page 13 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On August 3, 2022, between 10:15 a.m. and 11:30 a.m., survey staff toured the facility with the director of maintenance (DOM)-F. During the facility tour, survey staff observed the smoke alarms were not interconnected when DOM-F pressed the test button on several smoke alarms in the house. Survey staff also recommended adding smoke alarms in the main level living room and dining room due to deep bulkheads separating the space from the other smoke alarms on that level. DOM-F verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 14 Based on observation and interview the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On August 3, 2022, between 10:15 a.m. and 11:30 a.m., survey staff toured the facility with director of maintenance (DOM)-F. During the facility tour, survey staff observed the following: 1. The main level bathroom exhaust fan had lint and dust build-up. 2. There was a broken window pane in one of the double-hung windows in the dining room. 3. The upstairs bathroom exhaust fan had lint and dust build-up. 4. The basement staff bathroom had no exhaust fan and the operable window was painted shut. DOM-F verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810	Continued From page 15	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain fire safety	0 810		

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0 810	Continued From page 16	0 810		

and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).

The findings include:

During interview and record review on August 3, 2022, at 11:30 a.m. with the director of operations (DOO)-E and the site director (SD)-G, they stated they had not thought about specific needs for their residents in an emergency evacuation. They also were unaware of the training and evacuation drill requirements.

Review of the fire safety and evacuation policy showed the following:

1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who are wheelchair-bound and need assistance during an evacuation.

2. Evacuation drills were completed on

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0 810	Continued From page 17 05/11/2022 and 07/28/2022, quantity does not meet statute. There was no language in the policy regarding evacuation drills. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. There was no language in the policy regarding staff training. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. There was no language in the policy regarding resident training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides	01330		

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01330	Continued From page 18 or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and competency tested in all required topics for one of two employees (unlicensed personnel (ULP)-D) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on January 10, 2022, to provide direct care services to the licensee's residents. ULP-D employee training record lacked evidence they successfully completed practical skills evaluations as required for training in the following areas: -documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; -appropriate and safe techniques in personal hygiene and grooming, including:	01330		

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01330	Continued From page 19 -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; ULP-D's employee record lacked evidence of demonstrated competency in the following areas: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; On August 2, 2022, at approximately 4:25 p.m., registered nurse (RN)-B confirmed employee records of ULP-D lacked evidence of completed competency evaluations as indicated above. The licensee's Training and Competency Evaluations for Unlicensed Personnel, dated July 16, 2021, directed newly hired personnel receive training on topics required by Minnesota statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01330		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01540		

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01540	Continued From page 20	01540		

dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure employees received the required hours of dementia care training for one of two employees (unlicensed personnel (ULP)-C) with training records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).
The findings include:

ULP-C was hired on November 19, 2019, to provide direct care services to the licensee's residents.

The employment record of ULP-C lacked documentation of the required eight hours of initial dementia care training within 80 working hours of the employment start date.

On August 2, 2022, at approximately 2:45 p.m., director of operations (DO)-E confirmed ULP-C had not completed the required initial dementia

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01540	Continued From page 21 training because of staff turnover. The licensee's Orientation for All Staff policy, dated July 16, 2021, indicated orientation for employees must include dementia training. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure resident reassessment and monitoring did not exceed 90 days from the last date of the assessment for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on March 13, 2009, under the licensee's comprehensive home care license; the licensee's assisted living facility licensee became effective August 1, 2021. R1's record lacked documentation of a resident reassessment within 90 calendar days of the previous assessment, which were completed on January 20, 2022, and July 7, 2022. On August 2, 2022, at approximately 1:30 p.m., registered nurse (RN)-B confirmed the licensee did not complete R1's reassessment within 90 days of the previous assessment as required. The licensee's Assessments, Monitoring, and Reassessment's policy, dated August 14, 2015, directed resident reassessment and monitoring be conducted at least every 90 days. No further information was provided.	01620		

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01620	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included signatures or other authentication by the residents and agreement on the services to be provided for one of one resident (R1) with record reviewed.	01640		

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01640	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on March 13, 2009, with diagnoses to include dementia, traumatic brain injury, depression, and chronic pain. R1 required assistance with personal care reminders, meals, and medication administration. R1's undated service plan, was not signed by R1 or representative of R1. On August 2, 2022, at approximately 11:30 a.m., registered nurse (RN)-B stated the licensee failed to obtain R1's signature on the service plan. A policy titled, Service Plans, dated August 5, 2021, directed service plans and any revisions to service plans will have a signature or other authentication by the facility and by the resident. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 25 (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

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PEACE HOME	4953 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55419

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 26 medication management. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included traumatic brain injury. R1's undated service plan indicated the resident received medication management services. R1's medication list, updated July 5, 2022, included pain medication, depression medication, calcium supplement, and dementia medication. R1's assessment, dated September 23, 2021, lacked a medication management plan to include required content noted below: -identification of persons responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arose with medication management services; and -any resident-specific requirements relating to	01730		

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01730	Continued From page 27 documenting medication administration, verifications that all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On August 2, 2022, at approximately 2:00 p.m. registered nurse (RN)-B and director of operations (DO)-E confirmed R1's record lacked evidence of a medication management plan to include the above noted content. The licensee's Medication, Treatment and Therapy Management Plan policy, dated July 29, 2021, directed the RN conduct an assessment, develop an individualized plan based on the client's needs and preferences, and describe how the medication will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of one resident (R3) with	01890		

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	30414	A. BUILDING: _____ B. WING _____	08/03/2022

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01890	Continued From page 28 medication storage reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 2, 2022, at approximately 8:40 a.m., the surveyor observed the narcotic medication storage area and narcotic administration logbook for R3. Lorazepam 0.5 mg tablets had an expiration date of 6/22/2022. Lorazepam 0.5 mg tablets were administered to R3 on 6/26/22, 7/4/2022, 7/6/2022, 7/8/2022, 7/24/2022, and 7/25/2022. On August 2, 2022, at approximately 9:00 a.m. registered nurse (RN)-B verified the licensee failed to discard expired narcotic medication. The licensee's Medication Administration policy, dated September 17, 2015, directed staff follow the "8" rights of medication administration, including, but not limited to right expiration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications	01910		

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01910	Continued From page 29 (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01910		

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01910	Continued From page 30 The findings include: R2's medical record included a discharge summary which indicated R2 discharged from the facility on June 20, 2022, to an assisted living facility. R2's record lacked documentation of medication disposition upon discharge from facility to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On August 2, 2022, at approximately 11:15 a.m., registered nurse (RN)-B confirmed R2's discharge summary did not include the disposition of medication. The licensee's Disposal of Medication policy, dated September 17, 2015, directed when medication management services are no longer provided, the resident's medications must be returned to the resident or destroyed, and the disposition documented. No further information provided. Time period for correction: Twenty-one (21) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety	02040		

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02040	Continued From page 31	02040		

risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and
(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).

The findings include:

Survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee did not provide the requested documentation.

During interview on August 3, 2022, at 11:30 a.m., with the director of operations (DOO)-E and the site director (SD)-G both stated they don't have a hazard vulnerability assessment.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one

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02040	Continued From page 32 (21) days	02040		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and	02170		

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02170	Continued From page 33 (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to write an individual activity plan for one of one resident (R1) with records reviewed This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee had a current assisted living with dementia care license. R1's record lacked the development of an individualized activity plan and evidence R1 was evaluated for activities according to the licensing rules of the facility to include the following: - identification of activities for behavioral interventions On August 2, 2022, at approximately 1:53 p.m., director of operations (DO)-E confirmed evaluations for activities and individual activity plans had not been completed for R1. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

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Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/01/22*
Time: 13:00:00
Report: 8041221195

Food and Beverage Establishment Inspection Report

Location:
Peace Home
4953 Aldrich Avenue South
Minneapolis, MN55419
Hennepin County, 27

Establishment Info:
ID #: 0037514
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528242345
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

SHELL EGGS STORED ON THE TOP SHELF ABOVE READY-TO-EAT FOODS IN THE SECOND LEVEL FRIGIDIAIRE REFRIGERATOR. PROPER FOOD STORAGE ORDER REVIEWED WITH PERSON IN CHARGE. EGGS WILL BE STORED ON THE BOTTOM SHELF TO PREVENT CROSS CONTAMINATION.

Comply By: 08/01/22

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS FOODS (SHELL EGGS, CHEESE, MILK) IN THE SECOND LEVEL FRIGIDAIRE REFRIGERATOR MEASURED 49-50 DEG F. DISCARD TCS FOODS. TEMPERTURE DIAL IN UNIT WAS TURNED DOWN DURING INSPECTION. VERIFY UNIT IS RUNNING AT 41 DEG F OR BELOW.

Comply By: 08/01/22

4-700 Sanitizing Equipment and Utensils

4-702.11 ** Priority 1 **

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

FACILITY IS WASHING DISHES IN ONE BASIN OF THE TWO BASIN SINK (ONE BASIN IS USED FOR HANDWASHING). PROVIDE ADDITIONAL CONTAINERS TO RINSE AND SANITIZE

DISHES WITH AN APPROVED SANITIZING SOLUTION UNTIL DISH MACHINE IS REPAIRED.
Comply By: 08/01/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CERTIFIED FOOD PROTECTION MANAGER ON SITE. MANAGER HAS TAKEN A FOOD SAFETY COURSE, BUT STILL NEEDS TO TAKE EXAM AND APPLY FOR STATE CFPM CERTIFICATE.

Comply By: 08/01/22

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

LAMINATE COUNTER ABOVE THE DISHWASHER IS PULLING AWAY FROM THE WALL AND NEEDS TO BE REPAIRED.

Comply By: 08/22/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

1. UNDERCOUNTER DISHWASHER IS NOT WORKING AND MAY NEED TO BE REPLACED. VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS AT LEAST 160 DEG. F FOR SANITIZING. 2. FRIGIDAIRE REFRIGERATOR IS RUNNING WARM.

Comply By: 08/15/22

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	3	0	3

Inspection was completed with Rosa Awraris (House Manager) and Ifrah Aden (Site Director). Robyn Woolley and Rhonda Makela were the HRD Nurse Surveyors present.

Kitchen is residential and food is prepared for same day service only. There were nine residents on site at time of inspection. The basement has a dry storage area and chest freezer. The kitchen is on the main level and the second level has an additional refrigerator for food storage. The stove on the second level is not being used.

Establishment has a residential NSF dishwasher with a sanitizing cycle option. Dish machine is not currently working. Thermal strips provided for establishment to verify utensil surface temperature is at least 160 Deg. F once it is repaired. Cleaning and Sanitizing fact sheet sent with report.

Cabinets are wood with a hollow base, countertop is laminate.

Employee illness policy and logging requirements reviewed. Also discussed dishwashing procedures,

restrictions concerning serving a highly susceptible population, vomit clean-up procedures, handwashing and glove-use.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041221195 of 08/01/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

Roza Awraris
House Manager

Signed: Sarah Conboy

Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us